

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

-60-035596

Registration District No. 201

Primary Registration District No. 3048

Registrar's No. 225

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		c. CITY OR TOWN Skidmore	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Francis Hospital		d. STREET ADDRESS (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROLAND SPHAR BODLE		4. DATE OF DEATH Month Day Year 9 23, 1960	
5. SEX male	6. COLOR OR RACE cau	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9, 25, 1915
9. AGE (last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling St. operator	
11. BIRTHPLACE (City and state or country) Skidmore, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Bodle		13b. MOTHER'S MAIDEN NAME Leta Pruitt	
14. NAME OF HUSBAND OR WIFE Dorothy Bodle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, yes known) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 495-07-2206		17. INFORMANT Address Mrs Dorothy Bodle, Skidmore, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO (b) Polycythemia Vera. DUE TO (c) Hypertension. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension.		INTERVAL BETWEEN ONSET AND DEATH 3 hours 6-7 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1957 to 9-23-60 and last saw him alive on 9-23-60 . Death occurred at 8 00 on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) A. Edunake M.D.	
22b. ADDRESS Maryville, Mo.		22c. DATE SIGNED 7-23-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City, town, or county) Skidmore Mo.	
24. FUNERAL DIRECTOR Atchison Funeral Home, Maryville, Mo.		25. DATE RECD. BY LOCAL REG. 9-24-60	
26. REGISTRAR'S SIGNATURE Bess Bolt			

(Licensed Embalmer's Statement on Reverse Side)

OCT 19 1960

OCT 4 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

G. M. Alchier

Licensed Embalmer No.

227

P. O. Address

Maryville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

• If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.